Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Christopher Tatton, a prisoner at HMP Rye Hill, on 28 February 2025

## A report by the Prisons and Probation Ombudsman

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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In March 2020, Mr Christopher Tatton was sentenced to 19 years in prison for sexual offences. He died of sepsis caused by a chest infection on 28 February 2025, at HMP Rye Hill. He was 77 years old. We offer our condolences to Mr Tatton's family and friends.

4. The Ombudsman's office wrote to Mr Tatton's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They raised some concerns about his care which have been addressed in the clinical review.

5. NHS England commissioned an independent clinical reviewer to review Mr Tatton's clinical care at HMP Rye Hill.

6. The clinical reviewer concluded that the clinical care Mr Tatton received at Rye Hill was of a good standard and at least equivalent to that which he could have expected to receive in the community. However, she found that NEWS2 assessments (to assess clinical deterioration) were not always completed, and consideration of possible sepsis was not made or recorded between 23 and 24 February when Mr Tatton became acutely ill. We recommend:

   **The Head of Healthcare should undertake a training needs analysis regarding assessment of the acutely ill patient including the use of NEWS2 assessment, with the aim of identifying all healthcare staff who may need additional or refresher training.**

7. The clinical reviewer made three other recommendations not related to Mr Tatton's death that the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Tatton's care. We did not find any non-clinical issues of concern.

9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. Practice Plus Group provided an action plan which is annexed to this report.

10. We sent a copy of our initial report to Mr Tatton's next of kin. They did not notify us of any factual inaccuracies.

**Adrian Usher** **September 2025**
**Prisons and Probation Ombudsman**

## Inquest

At the inquest, held on 15 December 2025, the Coroner concluded that Mr Tatton died from natural causes.

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